Medicaid Information Bulletin

April 2002

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Medicaid Information

- **Salt Lake City area, call 538-6155.**
- **In Utah, Idaho, Wyoming, Colorado, New Mexico, Arizona and Nevada, call toll-free 1-800-662-9651.**
- **From other states, call 1-801-538-6155.**

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Send a Publication Request Form.

- **by FAX: 1-801-536-0476**
- **by mail to: Division Of Health Care Financing Box 143106, Salt Lake City UT 84114-3106**

02 - 26 Medicaid Budget Hearing for Fiscal Year 2003

The Department of Health invites you to a special Medical Care Advisory Committee (MCAC) meeting to obtain public input on the Medicaid and UMAP (Utah Medial Assistance Program) budgets for Fiscal Year 2003. The meeting will be held Thursday, June 20, 2002 from 4:00 p.m. until 6:00 p.m. at the Cannon Health Building in Salt Lake City (288 North 1460 West), Room 114.

Note: The Cannon Health Building is a secured building. Access Room 114 directly by entering the east entrance by the Health Clinic and Day Care. If you choose to use the main entrance on the south side of the building, you must obtain a visitor's pass and be escorted to room 114.

Fiscal Year 2003 is July 1, 2002 through June 30, 2003. The MCAC is an advisory group which recommends funding and program directions to the Department of Health.

If you know of special medical needs not being met by the Medicaid or UMAP programs, or want to speak on a budgetary matter of importance to you, please come prepared to make a short (no more than five minutes) presentation to the Committee. Copy services will be provided if you have a handout. SIGNED PETITIONS ARE ENCOURAGED. Your input will assist the MCAC in recommending a budget that will be more representative of Medicaid and UMAP providers and clients.

If you cannot attend the public hearing, but would like to write to the MCAC Committee about special medical needs, please mail your comments by Monday, June 03, 2002, to:

MCAC Committee
Division of Health Care Financing
Box 143103
Salt Lake City, UT 84114-3103

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02 - 27 Seven Prescription Limit

Because of a $200 million state revenue shortfall, Medicaid has had to reduce expenditures. Our goal throughout the reduction process has been to minimize adverse impacts to clients. We have NOT cut eligibility or optional services. However, when our proposed cuts were announced at the Medical Advisory Committee meeting last December, clients and advocacy groups raised serious concerns about the seven prescription limit. Based on comments, major modifications to the emergency rule were made before it went into effect on January 1.

While the seven prescription limit will still be imposed, we continued to fine-tune the program. Under our revised rule, the following processes will occur:

- We will exclude from the limit most drugs that treat conditions such as heart problems, high blood pressure, diabetes, transplant rejection, hemophilia, high cholesterol, HIV/AIDS, and most antibiotics.
- We will allow a personal medical exception to the limit if one is needed. We will not ask the client to request the exception. We will look at prescription drug usage through our computer system.
- If, after exclusions, the number of prescriptions exceeds seven, we will perform a review in consultation with the client's personal physician. The physician will have the final say on what is prescribed.
- If a limit is imposed and the client has a change in medical needs, the client will be able to receive the new medications. However, this may trigger a new review.
- The reviews will start with clients who requested the individual medical exception in January.

The outcome of the review may determine that no change is needed; or that the client will have to pay for non-essential prescriptions; or that the client must change to less expensive alternative medicines.

Client Notice

A client will be notified by letter when the case has been reviewed and advised if a change is necessary. If a change is required, the client may wish to discuss the change with his physician and pharmacist.

A copy of the notice sent to clients to inform them of the new Medicaid policy in regard to the limit on prescriptions is available on-line at:

www.health.state.ut.us/medicaid/rxlimit2.pdf ☐

This bulletin is available in editions for people with disabilities.
Call Medicaid Information:
538-6155 or toll free 1-800-662-9651.

02 - 28 Rural Health Clinic Services: Co-Payment Required; Encounter Billing Code Change

Effective April 1, 2002, many adult Medicaid clients will be required to make a $2.00 co-payment for services in a Rural Health Clinic. Both managed care and fee-for-service clients can have a co-pay. The client's Medicaid Identification Card will state when a co-payment is required and for what type of services. The clinic is responsible to collect the co-payment at the time of service or bill the client. Rural Health Clinic "encounter rates" will be adjusted to reflect these co-payments. Therefore, no message regarding co-payments will appear on the clinics' remittance statements.

This co-payment requirement is an expansion of the policy announced in October 2001, bulletin 01 - 92, Co-payment for Physician, Podiatry, and Outpatient Hospital Services. Refer to that bulletin for specific information on the co-payment message on the Medicaid Card, exempt services, exempt clients, such as pregnant women, co-payment amount, and co-payment maximums per client. The October bulletin is available on-line at:
www.health.state.ut.us/medicaid/october2001.pdf

Information on co-payments is also in SECTION 1 of the Utah Medicaid Provider Manual, GENERAL INFORMATION, Chapter 6 - 8, Exceptions to Prohibition on Billing Patients, item 3. View the on-line version at:
www.health.state.ut.us/medicaid/SECTION1.pdf

Encounter Billing Code Change

For date of service on or after April 1, 2002, use code T1015 to bill. For services prior to April 1, use code Y0099.

Provider Manual Updated

The co-payment requirement is added to the Utah Medicaid Provider Manual for Rural Health Clinic Services, SECTION 2, as a new Chapter 1 - 5. The change in billing code and an index are also added. Providers will find a new SECTION 2 attached to update their manual. ☐

02 - 29 Documentation and Signature Requirements for Medical Records

Bulletin 02 - 01, Documentation and Signature Requirements for Medical Records, issued in January 2002, clarified the Medicaid documentation and signature requirements for medical records. The heading of Chapter 10 - 4, Documentation and Signature Requirements, item B, Signature Requirement, sub-item 3, has been corrected to "Accepted Alternative Signature". The on-line version of SECTION 1 of the Utah Medicaid Provider Manual is correct. View page 38 at www.health.state.ut.us/medicaid/SECTION1.pdf. ☐

02 - 30 Primary Care Network: New Utah Waiver

Secretary of Health and Human Services Tommy Thompson approved a Utah Medicaid demonstration waiver to expand benefits for primary care and preventive services to about 25,000 Utah residents who otherwise would not have access to health coverage. The waiver allows Utah's Medicaid program to reduce some benefits to current Medicaid eligible adults in order to reallocate these funds to offer some coverage to working individuals who have no health care coverage in the workplace.

Read about the waiver and view the chart comparing the waiver to the CHIP and Medicaid programs on-line at www.health.state.ut.us/medicaid/html/pcn_waiver.html
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02 - 31 Health Common Procedure Coding System - 2002 Revisions

Effective for dates of services on or after January 1, 2002, Medicaid began accepting the 2002 version of the Health Common Procedure Coding System (HCPCS). HCPCS codes include the 2002 Physicians' Current Procedural Terminology (CPT) codes. You were instructed in the January 2002 bulletin to continue to obtain prior authorization required for procedures on the 2001 list, even though new codes may be added for the same or similar procedures, or codes may be changed on the 2002 list.

Other articles in this April 2002 Medicaid Information Bulletin contain details about coding changes for services by physicians, medical suppliers and so forth. Any 2001 HCPCS codes discontinued in 2002 may be used for dates of services prior to April 1, 2002. For services on and after April 1, 2002, providers must use the 2002 HCPCS codes. If you have a question concerning billing the 2002 HCPCS codes, please contact Medicaid Information. ☐

02 - 32 UMAP: Speciality Care Not Reimbursable

Due to the severe budget shortfalls the State is facing this year, as of April 1 speciality care will not be a reimbursable service for UMAP clients, unless such care is provided during certain inpatient hospital stays.

Specialty care means any physician service which is rendered or customarily rendered outside of a covered physician's office or clinic. A covered physician is one classified by Medicaid as having a practice specialty in General Preventive Medicine (01), Family Practice (08), Internal Medicine (Proctology (11), Obstetric-Gynecology (16), Public Health (47), General Practice (57) or Gynecology (58).

The Department of Health is in the process of developing a volunteer specialty network. We understand physicians have very full schedules, but we hope you will consider donating a few hours each month to provide specialty care to the UMAP patients you currently serve. ☐

02 - 33 Pharmaceutical Products Covered by the Medicaid Physician Program: triptorelin pamoate (TRELSTAR®); epoeitin alpha (Epogen, Procrit)

New pharmaceutical products on the market are often covered by the Medicaid Physician Program and not covered by the Pharmacy Program. The following products are examples: Synagis, Remicade, Zemplar, TRELSTAR®. Trelstar does not yet have a specific J code. Use J3490 until a code is assigned.

Also, some products removed from coverage by the Pharmacy Program continue to be available through the Physician Program. For example, effective April 1, 2002, epoeitin alpha (Epogen, Procrit) will only be available through the Physician Program.

This information is added to the Utah Medicaid Provider Manual for Pharmacy Services, SECTION 2, Chapter 7, Non-covered Drugs and Services, as a new item M. Providers will find page 26 attached to update SECTION 2. A vertical line in the left margin on page 26 marks where text was added. ☐

02 - 34 Medicare Crossovers Address

The address for Medicare and Medicare Crossover claims has changed from Department 14 to Department 53. This part of the crossover address listed in the Utah Medicaid Provider Manual, SECTION 1, Chapter 11 - 7, Filing Crossover Claims, has been corrected. The complete, correct address is:

Medicare/Medicaid Crossovers
Department 53
P.O. Box 30269
Salt Lake City, UT 84130-0269

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02 - 35 Medical Transportation: Transportation Criteria by Contract; Y Codes Replaced by HCPCS Codes

Transportation criteria under the sole source Medicaid contract have been added to the Utah Medicaid Provider Manual for Medical Transportation Services. The criteria restate the transportation contract with PickMeUp Medical Transport. The criteria are added to SECTION 2 of the manual as a new Chapter 3 - 7, Non-emergency Transportation Through Sole Source Contract under a 1915 (b) Waiver.

HCPCS Transportation Codes

In the chapters listed below, new HCPCS transportation codes replace state-specific Y codes.

7 - 1, Taxi Codes

Code T2004, Non-emergency transportation; commercial carrier, multiple rider, replaces code Y1121.

7 - 3, Specialized Van Service Codes

Code T2001, Transportation attendant or escort, replaces codes Y1160 and Y1172.

Code S0209, Wheelchair van, mileage, per mile replaces code Y1130, Specialized Van, round trip.

7 - 5, Ambulance Codes

Code T2006, Ambulance response and treatment, no transport, replaces code Y1190.

Medical Transportation Manual Updated

Transportation providers will find attached pages to update SECTION 2 of the Utah Medicaid Provider Manual for Medical Transportation Services. A vertical line in the left margin marks where text has changed. New codes are in bold print. An asterisk (*) in the margin marks where a code was deleted. ☐

02 - 36 Medical Supplies List Revised

This bulletin describes coverage of medical supply codes included in the 2002 Health Common Procedure Coding System (HCPCS) procedure codes update, as well as other corrections. Only codes which are on the Medical Supplies List are covered by Medicaid. For more information on the effective dates for HCPCS updates, refer to Bulletin 02 - 31, Health Common Procedure Coding System - 2002 Revisions.

Non-Covered Codes

Medical supply codes which are not on the Medical Supplies List are **not** covered by Medicaid.

Changes to the Medical Supplies List

Code deletions, revisions, and additions are summarized in the table below. HCPCS descriptors for covered codes are abbreviated in this bulletin. Codes are grouped according to their category on the Medical Supplies List.

Medical suppliers and providers of physician services will find attached the pages needed to update the Medical Supplies List. [To save costs of printing and mailing, only updated pages are attached. Do not discard pages for which there is no replacement.] New codes are in bold print. A vertical line in the margin of a page indicates where text was changed or added. An asterisk (*) in the margin marks where a code was removed. (Medical suppliers, please note: When replacing the Medical Supplies List, be sure to keep the DMERC lists in your Medical Supplies Manual.)

First Aid Supplies, Wipes, Swabs, page 3

A4927: descriptor updated.

Urinary Catheters, pages 5 - 6

A4329: discontinued effective 4-01-02

A4351, A4352, A4358, A4860: descriptors updated.

Miscellaneous Supplies, page 9

A4772, A4773, E0602: descriptors updated.

Enteral, Parental Nutrition, page 10

B4084: discontinued effective 4-01-02.

B4086, added effective 1-01-02.

B9006LR, descriptor updated.

Pumps, page 17

E0602: descriptor updated.

A4230, added effective 1-01-02. [Reference: bulletin 02 - 14, Medical Supplies: Insulin Pump, Non-needle Cannula, published January 2002.]

Decubitus Care, page 22

A6196, A6197, A6198, A6199: descriptors updated.

Hospital Beds and Accessories, page 26

E0298: discontinued effective 4-01-02

Oxygen & Related Respiratory Equipment, page 30

K0532LR: rental only

K0533LR: descriptor updated, rental only.

[Reference: Bulletin 01 - 22, Medical Supplies: Respiratory Assist Device, published January 2001.]

Suction Pumps and Room Vaporizers, page 33

E0600: descriptor updated.

Monitoring Equipment, page 33

E0609: discontinued effective 4-01-02.

Lower Limb: Hip, Knee, Ankle, page 46

L1930, L1940: descriptors updated.

Additions to Lower Extremity: Orthoses, page 48

L2415: descriptor updated.

Prosthetics, Lower Limb, pages 51 - 52

L5300, L5320, L5340, L5667, L5669: discontinued effective 4-01-02.

L5311, added effective 1-01-02.

L5331, added effective 1-01-02.

Breast Prosthetics, page 57

L8001, added effective 1-01-02. . .

L8002, added effective 1-01-02.

Hearing Aids, page 58

Hearing aids require written prior authorization as of October 1, 2001 [Reference bulletin 01 - 102, Hearing Aids Require Written Prior Authorization, published October 2001.]

□

02 - 37 Venipuncture (G0001) and Finger Stick Related Procedures, 82948, 85013, 82962

The January 2002 article 02 - 13, Venipuncture (G0001); Blood Glucose by Reagent Strip (82948), is updated to include two more codes where code G0001 for venipuncture will not be paid. Venipuncture is not a covered service with the following three codes:

82948, blood glucose by reagent strip
85013, spun microhematocrit, which is also completed by finger stick
82962, glucose blood home monitoring device

None of these are venipuncture procedures. Therefore, code G0001 for venipuncture will not be paid with any of the CPT codes. However, if other blood specimens are ordered which require venipuncture, G0001 payment will be allowed.

This information is added to SECTION 2 of the Utah Medicaid Provider Manual for Physician Services, SECTION 2, Chapter 3, LIMITATIONS, under item F (1), page 18. The corrected page is attached. A vertical line in the left margin marks where text has been added. The on-line copy of the Physician Services Manual is at: www.health.state.ut.us/medicaid/physician.pdf. ☐

02 - 38 Laboratory Services: CLIA Requirements

The CLIA list is updated for 2002. Providers will find a copy attached to update the Utah Medicaid Provider Manuals for Physician Services and Laboratory Services. Codes are added to the columns titled "Certificate of Waiver" and "Codes Excluded from CLIA Requirements" and the list of CLIA Waiver Kits. Codes newly added are in bold print.

Codes added are:

Certificate of Waiver and CLIA Waiver Kits: 83605 QW, 86294 QW, 86618 QW

Codes removed are:

Certificate of Waiver: 82120 QW

Certificate for . . . PPMP: 87072 QW

Certificates of Compliance, . . . : P3001

Codes Excluded from CLIA Requirements: Q0115, G0027, 83013, 83014, 83019, 85095, 85102, 86585, 86910, 86911, 80103, 88125, 88170, 88171

CLIA List On-Line

The current CLIA list is available on the Internet at www.health.state.ut.us/medicaid/clia.pdf. ☐

02 - 39 Audiology: Y Codes Replaced by HCPCS Codes

The Utah Medicaid Provider Manual for Audiology Services is updated to replace discontinued, state-specific Y codes with new HCPCS codes. The changes are listed below.

- Y5030 replaced by V5242, Hearing aid, analog, monaural, ITC, and V5243, Hearing aid, analog, monaural, CIC. Refer to the CRITERIA and COMMENTS for codes V5242 and V5243 on page of the policy manual. A reference to Y5030 under code Y2100, Assistive Listening Device, is replaced by reference to V5242.
- Y0381 replaced by V5266, Battery for use in hearing device.
- Y1320 replaced by V5275, Ear impression, each
- Y5130 replaced by V5248, Hearing aid, analog, binaural, CIC; and V5249 Hearing aid, analog, binaural, ITC
- Y5135 replaced by V5254, Hearing aid, digital, monaural, CIC; V5255, Hearing aid, digital, monaural, ITC; V5256, Hearing aid, digital, monaural, ITE and V5257, Hearing aid, digital, monaural, BTE. In addition, a comment has been added to the LIMITS column: “Code includes conformity evaluation and ear molds. Hearing aids must be guaranteed by the manufacturer for a period of at least one year.”

Audiology Manual Updated

The code replacements have been made in SECTION 2, Chapter 6, Procedure Codes, on pages 10 through 12. V codes are listed in numerical order, followed by state-specific Y codes. A reference to code Y5135 is removed from Chapter 5 - 3, Digital Hearing Aids. Audiologists will find attached pages to update their manuals. New codes are in bold print. A vertical line in the left margin marks where text was changed. ☐

02 - 40 Year 2002 CPT Codes

The Medical and Surgical Procedures List in the Utah Medicaid Provider Manual for Physician Services has been updated in accordance with Year 2002 Current Procedural Terminology (CPT) codes. The list includes codes which are not covered by Medicaid, or require prior authorization, or have other limitations. This bulletin summarizes the changes to the list. HCPCS descriptors, abbreviated in this bulletin, are stated in full on the Medicaid list.

For more information on the effective dates of this year's revisions, refer to Bulletin 02 - 31, Health Common Procedure Coding System - 2002 Revisions.

Temporary Codes Not Covered

Codes ending with the letter "T" are a new category of temporary codes. They identify emerging technology, services, and procedures and allow data collection. CPT notes that inclusion neither implies nor endorses clinical efficacy, safety or the applicability to clinical practice, leading to questions of investigational or experimental status of the codes. As a result, Medicaid will not cover temporary codes 0001T through 00026T. This information is added to the last page of the Medical and Surgical Procedures List.

CPT Codes Not Covered

Medicaid does not cover the CPT codes listed below. The Medicaid list states these codes are "NOT A BENEFIT."

00797 Anesthesia for surgery for morbid obesity
01905 Anesthesia (for injection procedures) for myelography, diskography, and vertebroplasty. (Vertebroplasty is still considered experimental)
11981 Insertion, non-biodegradable drug delivery implant
11982 Removal, non-biodegradable drug delivery implant
11983 Removal with reinsertion, non-biodegradable drug delivery implant
20551 Injection; tendon origin/insertion
20553 Injection; single or multiple trigger point(s) . . . .
21485 Closed treatment of temporomandibular dislocation
36470 Injection of sclerosing solution; . . .
36471 Injection of sclerosing solution; . . . :
46020 Placement of seton
47370 Laparoscopy, surgical, ablation of one or more liver tumor(s) . . . .
47371 Laparoscopy; surgical, ...
47380 Ablation, open, of one or more liver tumor(s) . .
47382 Ablation, one or more liver tumor(s) . . . .
50320 Donor nephrectomy
53444 Insertion of tandem cuff (dual cuff)
54406 Removal of all components of a multi-component, inflatable penile prosthesis . . . .
54408 Repair of components of a multi-component, inflatable penile prosthesis
54410 Removal and replacement of all components of a multi-component, inflatable penile prosthesis . . . .
54411 Removal and replacement of all components of a multi-component inflatable penile prosthesis . . . .
54415 Removal of non-inflatable (semi-rigid) or inflatable (self contained) penile prosthesis . . .
54416 Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis .
54417 Removal and replacement of non-inflatable (semi-rigid) or inflatable (self contained) penile prosthesis .
57155 Insertion of uterine tandems and/or vaginal ovoids for clinical brachytherapy
58346 Insertion of Heyman capsules for clinical brachytherapy
64821 Sympathectomy; radial artery
64822 Sympathectomy; ulnar artery
64823 Sympathectomy; superficial palmar arch
76085 Digitization of film radiographic images with computer analysis for lesion detection and further physician review . . . .
76362 Computerized axial tomographic guidance for, and monitoring of, tissue ablation
76394 Magnetic resonance guidance for, and monitoring of, tissue ablation
77301 Intensity modulated radiotherapy plan . . . .
77418 Intensity modulated treatment delivery, ...
82274 Blood, occult, by fecal hemoglobin determination by immunoassay . . . .
83950 Oncoprotein, HER-2/neu
86141 C-reactive protein; high sensitivity (hsCRP)
86336 Inhibin A
87198 Cytomegallovirus, direct fluorescent antibody (DFA)
87199 Enterovirus, direct fluorescent antibody (DFA)
87803 Infectious Agent antigen detection by immunoassay . . . .
87804 Infectious Agent antigen detection by immunoassay . . . .
87902 Infectious agent genotype analysis by nucleic acid (DNA or RNA); Hepatitis C virus
88380 Microdissection (eg, mechanical, laser capture)
90473 Immunization administration by intranasal or oral route . . . .
90474 Immunization administration by intranasal or oral route . . . . and arteriovenous fistula by an indicator dilution method . . . .
90939 Hemodialysis access flow study . . . .
91123 Pulsed irrigation of fecal impaction
92136 Ophthalmic biometry by partial coherence interferometry . . . .
92973 Percutaneous transluminal coronary thrombectomy . . . .
92974 Transcatheter placement of radiation delivery device . . . .
93025 Microvolt T-wave alternans for assessment of ventricular arrhythmias
93613 Intracardiac electrophysiologic 3-dementional mapping . . . .
93701 Bioimpedance, thoracic, electrical
95250 Glucose monitoring for up to 72 hours . . . .
95965 Magnetoencephalography (MEG) recording and analysis . . . .

95966 (Magnetoencephalography) . . . .
95967 (Magnetoencephalography) . . . .
96000 Comprehensive computer-based motion analysis . .
96001 with dynamic plantar pressure measurements during walking
96002 Dynamic surface electromyography, during walking or other functional activities . . . .
96003 Dynamic fine wire electromyography, during walking or other functional activities . . . .
96004 Physician review and interpretation of comprehensive computer based motion analysis . . . .
96150 Health and behavior assessment . . . .
96151 re-assessment
96152 Health and Behavior intervention . . . .
96153 group
96154 family . . . .
96155 family . . . .

NOTE: The preceding codes for health and behavior assessment and intervention focus on the biopsychosocial factors involved with physical health and treatments. The codes have been reviewed with the Mental Health program manager who, in turn, reviewed them with Valley Mental Health staff. The decision is to not open the codes at this time. If these codes can be used in crosswalk for HIPPA, they will be addressed later. Since the emphasis is not medical and the mental health people do not intend to use the codes, they will remain non-covered.

96567 Photodynamic therapy of skin code added
97005 Athletic training evaluation
97006 Athletic training re-evaluation
99091 Collection and interpretation of physiologic data . . .
99289 Physician constant attention of the critically ill or injured patient during an interfacility transport . . . .
99290 each additional 30 minutes

Non-Covered Home Health Codes

The following codes describe home health visits by non-physician professionals. At this time they do not appear to meet the current Medicaid definitions for covered home health services, so they will remain non-covered. Medicaid will reevaluate these codes at a later time for applicability in the crosswalk of home health codes for HIPPA.

99500 Home visit for prenatal monitoring and assessment . . . .
99501 Home visit for postnatal assessment . . . .
99502 Home visit for newborn care and assessment
99503 Home visit for respiratory therapy care . . . .
99504 Home visit for patients receiving mechanical ventilation
99505 Home visit for stoma care and maintenance . . .
99506 Home visit for intramuscular injections
99507 Home visit for care and maintenance of catheter(s) . . . .
99508 Home visit for polysomnography and sleep studies
99509 Home visit for assistance with activities of daily living and personal care
99510 Home visit for individual, family, or marriage counseling
99511 Home visit for fecal impaction management and enema administration
99512 Home visit for hemodialysis . . . .
99539 Unlisted home visit service or procedure
99551 Home infusion for pain management
99552 Home infusion for pain management
99553 Home infusion for tocolytic therapy
99554 Home infusion for hematopoietic hormones
99555 Home infusion for chemotherapy
99556 Home infusion for antibiotics/antifungal/antiviral
99557 Home infusion for continuous anticoagulant therapy
99558 Home infusion for immunotherapy
99559 Home infusion of peritoneal dialysis
99560 Home infusion of peritoneal dialysis
99561 Home infusion of hydration therapy
99562 Home infusion of hydration therapy
99563 Home infusion of aerosolized pentamidine
99564 Home infusion of anti-hemophilic agents
99565 Home infusion of alpha-1 proteinase inhibitor
99566 Home infusion of long term intravenous treatment
99567 Home infusion of sympathomimetic agents
99568 Home infusion of miscellaneous drugs
99569 Home infusion, each additional therapy

T.B. Skin Test, Tine Method, Not Covered

As announced in the October 2001 issue of the Medicaid Information Bulletin, coverage of CPT code 86585, tine method of tuberculosis skin testing, ended October 1, 2001 (article 01 - 10, Tuberculosis Skin Testing: Tine Method No Longer Covered). This change is included with the HCPCS update of the Medical and Surgical Procedures list.

"S" and "G" codes

The section on "S" and "G" codes, on the last page of the CPT list, has been removed.

- "S" codes may be used by Medicaid.
- Six G codes that were listed under the heading "S" and "G" codes are discontinued or not covered. The codes removed from the list are G0202, G0203, G0204, G0205, G0206, and G0207.

Codes Discontinued

The following codes are discontinued and have been removed from the Medicaid list: 29815, 29909, 54402, 54407, 54409.

CPT Codes Requiring Prior Authorization

The CPT codes listed below are covered only with prior authorization, either written or telephone as indicated. Criteria are stated on the list dated April 2002.

Telephone Prior Approval Required for Codes Listed below

29805 Arthroscopy, shoulder, diagnostic. . . [Replaces 29815 which is discontinued April 1, 2002.]
29806 Arthroscopy, shoulder, surgical; capsulorrhaphy
33967 Insertion of intra-aortic balloon assist device, percutaneous.
33979 Insertion of ventricular assist device . . . .

Written Prior Approval Required for Codes Listed below

38220 Bone marrow aspiration.
38221 Bone marrow biopsy, needle or trocar.
** 64561 Percutaneous implantation of neurostimulator electrodes; sacral nerve.
** 64581 Incision for neurostimulator electrode implant . . .

****** New criteria for sacral nerve stimulation are added to Criteria #32. Refer to Bulletin 02 - 41, Criteria for Sacral Nerve Stimulation, or the April 2002 list titled Criteria for Medical and Surgical Procedures, page 29.

Codes Limited by Age

The following new CPT Codes are limited by age:

Covered for children less than twenty-one years of age

43313 Esophagoplasty for congenital defect
43314 with repair of congenital tracheoesophageal fistula
44126 Entrectomy resection of small intestine for congenital atresia
44127 . . . . with tapering
54162 Lysis or excision of penile post-circumcision adhesions
54163 Repair incomplete circumcision
54164 Frenulotomy of penis

Covered for children less than one year of age

49491 Repair initial inguinal hernia in preterm infant birth to 50 weeks old
49492 incarcerated or strangulated

Covered for children less than two years of age

87802 Infectious agent antigen for Group B streptococcus by immunoassay

CPT Code Requiring Documentation with Claim

Code 29999, Unlisted procedure, arthroscopy, is new. An unlisted CPT code does not require prior authorization. However, it does require that the provider attach documentation to the claim for physician review.

CPT Codes With Other Criteria

Two other groups of CPT codes do not require prior authorization, but are subject to new Medicaid criteria.

Removal of Benign or Premalignant Skin Lesions

11300 through 11313, Shaving of epidermal or dermal lesion . . .
11400 through 11446, Excision, benign lesion, except skin tag . . .
17000 through 17004, Destruction . . . all benign or premalignant lesions . . .
17006 through 17008, Destruction of cutaneous vascular proliferative lesions . . .
17110 through 17111, Destruction . . . of flat warts, molluscum contagiosum, or milia; . . .

Refer to bulletin 02 - 43, Criteria for Removal of Benign or Premalignant Skin Lesions, or the April 2002 list titled Criteria for Medical and Surgical Procedures, Criteria #34, page 31.

Trigger Point Injections

20552, Injection; single or multiple trigger point(s) . . . . Refer to bulletin 02 - 42, Criteria for Trigger Point Injections, or the April 2002 list titled Criteria for Medical and Surgical Procedures, Criteria #33, page 30.

Codes with Descriptor Changes

Descriptors for the following codes on the list have been corrected in accordance with HCPCS 2002: 21182, 21183, 21184, 33975, 33976, 33977, 33978, 43847, 43860, 52510, 58275, 58563, 58611, 76819, 83013, 87451, 97504, 97535, 97602, 97802, 97803, 97804, 99090, 99374, 99377, 99379.

Medical and Surgical Procedures List Updated

Providers of physician services will find attached a Medical and Surgical Procedures List dated April 2002 to replace the old list. New codes are in bold print. A vertical line in the margin marks where text was changed or added. An asterisk (*) marks where a code was deleted. For more information on effective dates, refer to Bulletin 02 - 31, Health Common Procedure Coding System - 2002 Revisions. ☐

02 - 41 Criteria for Sacral Nerve Stimulation

New criteria for sacral nerve stimulation, CPT codes 64561 and 64581, are added to Criteria #32 in the list titled Criteria for Medical and Surgical Procedures. This is an attachment to the Utah Medicaid Provider Manuals for Hospital Services and for Physician Services.

Providers will find pages attached to update the list. A vertical line in the margin marks where text was changed or added. In addition to the criteria update, an alphabetical index has been added to the list. ☐

02 - 42 Criteria for Trigger Point Injections

Effective April 1, 2002, limits are placed on code 20552, injection; single or multiple trigger point(s), one or two muscle group(s), referred to as trigger point injections. This policy is added to the Utah Medicaid Provider Manual for Physician Services, Chapter 3, Limitations, as a new item W, Trigger Point Injections. (Subsequent items in Chapter 3 are renumbered.) The limits are placed in a new Criteria #33 on the list titled Criteria for Medical and Surgical Procedures. This list is an attachment to the Utah Medicaid Provider Manuals for Hospital Services and for Physician Services.

Providers will find attached pages to update the list and page 19B to update SECTION 2 of their manuals. A vertical line in the margin marks where text was added. ☐

02 - 43 Criteria for Removal of Benign or Premalignant Skin Lesions

Effective April 1, 2002, Medicaid will cover removal of skin lesions only when the procedure is medically necessary and meets the requirements of Criteria #34 on the list titled Criteria for Medical and Surgical Procedures. Removal of common, benign skin lesions that do not pose a threat to function or health are considered cosmetic and are not covered by Medicaid.

The policy is added to the Utah Medicaid Provider Manual for Physician Services, Chapter 3, Limitations, as a new item V, Removal of Benign or Premalignant Skin Lesions (page 19B). Subsequent items in Chapter 3 are renumbered. A patient who wants the removal to improve appearance should be told that Medicaid will not cover the procedure. For complete information, refer to Criteria #34. Providers of physician and hospital services will find the criteria attached. ☐

02 - 44 Hospital Surgical Procedures (ICD-9-CM Codes)

Effective April 1, 2002, the Hospital Surgical Procedures Code List is updated to add four CPT codes which **require prior authorization** and are related to certain ICD-9 codes. Also, an ICD-9 code for sacral nerve stimulation is added to the list. The new CPT codes, and the ICD-9 codes to which they are related, are listed below. The CPT descriptor is abbreviated. Either telephone or written prior authorization (PA) is indicated.

ICD-9 Codes: 37.62, 37.66, Implantation of pulsatile heart assist system
Related to CPT codes (telephone PA): 33979, Insertion of ventricular assist device . . . .

ICD-9 Code: 788.31, Urge incontinence
Related to CPT code (written PA): 64561, Percutaneous implantation of neurostimulator electrodes; sacral nerve, and 64581, Incision for neurostimulator electrode implant; sacral nerve. . . .

ICD-9 Code: 66.2, 66.21, 66.22, 66.29 . . . bilateral endoscopic destruction or occlusion of fallopian tubes
Related to CPT code (telephone PA): 33967, Insertion of intra-aortic balloon assist device, percutaneous

ICD-9 Code: 80.21, Shoulder arthroscopy
Related to CPT code (telephone PA): 29805, Arthroscopy, shoulder, diagnostic . . . , and 29806, Arthroscopy, shoulder, surgical . . . ,

Codes with Descriptor Changes

Descriptors for the following CPT codes on the list have been corrected in accordance with HCPCS 2002: 33975, 33976, 33977, 33978, 58275, 58563, 58611.

Hospital Surgical Procedures List Updated

Providers will find pages attached to update the Hospital Surgical Procedures list. The new CPT codes are in bold print on pages 3, 6, 10, and 14. Other pages have descriptor changes marked with a vertical line in the margin. ☐

02 - 45 Injectable Medication Codes

This bulletin describes coverage of injectable medication codes (J - codes) included in the 2002 Health Common Procedure Coding System (HCPCS) procedure codes update. Reimbursement to physicians for these codes is made at 5% below Medicare's participating physician's allowable cost. HCPCS descriptors for covered codes, abbreviated in this bulletin, are given in full in the code list. Injectable medications which are not on the Medicaid Injectable Medications List are NOT covered by Medicaid.

For information on the effective dates of code changes, refer to Bulletin 02 - 31, Health Common Procedure Coding System - 2002 Revisions.

Discontinued Codes

The following codes are discontinued April 1, 2002, and have been removed from the Injectable Medications List:

J0340 Nandrolone Phenpropionate; Androlone; Durabolin
J0400 Trimethaphan camsylate; Arfonad
J0510 Benzquinamide; Emete-Con
J0590 Ethylnorepinephrine HCL; Bronkephrine
J0695 Monocid; Cefonicid Sodium
J0730 Chlorpheniramine Maleate; Chlor-Trimeton
J0810 Cortisone Acetate
J1090 Testosterone Cypionate; Depo-Testosterone
J1362 Erythromycin Gluceptate
J1690 Prednisolone Tebutate; Hydeltra T.B.A.
J1739 Hydroxyprogesterone Caproate; Pro-Depo; Hylutin
J1741 Hydroprogesterone caproate; Duralutin
J1930 Propiomazine; Largon
J1970 Methotrimeprazine; Levoprome
J2240 Metocurine Iodide
J2330 Thiothixene; Navane
J2350 Niacinamide; Niacin
J2480 Hydrochlorides of opium alkaloids; Pantopon
J2512 Pentagastrin
J2640 Prednisolone Sodium Phosphate; Hydeltrasol
J2675 Progesterone
J2860 Secobarbital Sodium; Seconal Sodium
J2970 Methicillin Sodium; Staphcillin
J3080 Chlorprothixene; Taractan
J3270 Imipramine HCL; Tofranil
J3390 Methoxamine HCL; Vasoxyl
J3450 Mephentermine Sulfate; Wyamine Sulfate
J7315 Sodium Hyaluronate
S0086 Verteporfin

An asterisk (*) in the margin of the Injectable Medications List marks where a code was removed.

Codes Added

Codes in the following list are covered by Medicaid.

J0587 Botulinum toxin type b, per 100 units
J0692 Cefepime hydrochloride, 500 mg
J0706 Caffeine citrate, 5mg
J0744 Ciprofloxacin . . . .
J1056 Medroxyprogesterone Acetate / Estradiol Cypionate, 5mg / 25mg
J1270 Doxercalciferol, 1 mcg
J1590 Gatifloxacin, 10mg
J1655 Tinzaparin sodium, 1000 IU
J1755 Iron sucrose, 20mg
J1835 Itraconazole, 50 mg
J2020 Linezolid, 200mg
J2940 Somatrem, 1 mg
J2941 Somatropin, 1 mg
J3100 Tenecteplase, 50mg
J3395 Verteporfin, 15mg
J7302 Levonorgestrel-releasing intrauterine contraceptive system, 52 mg
J7316 Sodium hyaluronate, 5 mg . . . .
J9017 Arsenic trioxide, 1mg
J9300 Gemtuzumab ozogamicin, 5mg
TRELSTAR®, use J3490 until code is assigned.

New, covered codes are added to the Injectable Medications List in bold print.

Descriptors Revised

Descriptors for the following codes are revised on the Injectable Meditations List: J2993,Reteplase; J7504, Lymphocyte immune globulin; J7618, J7619, Albuterol

Injectable Medications List Updated

Providers of physician services will find attached an updated list for their manuals. Other providers who want the revised list should contact Medicaid Information; ask for the April 2002 Injectable Medications List. ☐

02 - 46 Anesthesiologists: ASA Code List Updated

The list American Society of Anesthesiologists (ASA) Codes Associated With CPT Surgical Codes Which May Require Prior Authorization has been updated. This list is an attachment to the Utah Medicaid Provider Manual for Physician Services. Because of HCPCS 2002 changes, discontinued codes are removed, and new codes are added. For more information regarding the effective dates of revisions, refer to Bulletin 02 - 31, Health Common Procedure Coding System - 2002 Revisions.

Discontinued ASA Code

00855 Anesthesia for cesarean hysterectomy

New ASA Codes

Codes added to the ASA Code list are:

00851 Anesthesia for . . . laparoscopy; tubal ligation/transection.
00869 Anesthesia for extraperitoneal procedures in lower abdomen . . .
01964 Anesthesia for abortion procedures.

Anesthesiologists are NOT required to request prior authorization. The surgeon must obtain prior authorization, when required, for procedures identified in the Medical and Surgical Procedure Code List, an attachment to the Utah Medicaid Provider Manual for Physician Services. However, the anesthesiologist must use the prior authorization number obtained by the surgeon when billing an ASA code related to a CPT procedure that requires authorization. For more information, refer to the instructions on the ASA code list.

ASA Code List Updated

Providers of physician services will find an updated ASA code list attached to replace the 2001 list. The new codes are in bold print on the April 2002 list. An asterisk (*) marks where a code was deleted. ☐

02 - 47 Monthly Limit on Asthma Inhalers

Effective April 1, 2002, as per decision by the DUR Board, the cumulative number of oral or nasal anti-inflammatory inhalers in any 30-day period is limited for a Medicaid client. The limit is set by class, except for Foradil and Serevent which are limited by NDC number. This means the highest number in any one class is the maximum. When there are more than two sizes or strengths for a given product, the limit is based on the largest size or strength.

The products are listed by generic name, brand name, product size, doses per inhaler, and maximum number of inhalers per month on the Drug Criteria and Limits list dated April 2002, pages 21 - 22. Providers of physician and of pharmacy services will find attached the pages to update the list in their manuals. A vertical line in the left margin of the page marks where text is added.

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02 - 48 Codes NOT Authorized for an Assistant Surgeon

The list Codes NOT Authorized for An Assistant Surgeon in the Utah Medicaid Provider Manual for Physician Services has been updated as a result of HCPCS 2002. (Codes on this list may be covered by Medicaid but are NOT covered for an assistant surgeon.) Discontinued codes are removed, and new codes are added. Providers of physician services will find a new list attached. For more information regarding the effective dates of revisions, refer to Bulletin 02 - 31, Health Common Procedure Coding System - 2002 Revisions.

Codes Discontinued

The CPT codes which follow are removed from the list because they are discontinued: 26585; 54510.

Codes Added to List "NOT Authorized for An Assistant Surgeon"

The following codes are NOT covered for an assistant surgeon and have been added to the list:

10021	25430	35686	53446
10022	25431	36002	53448
20526	25651	36820	53853
20552	25652	38220	54162
24300	25671	38221	54163
24332	26340	43313	54164
24343	29086	44203	59001
24344	29805	44204	64561
24345	29806	44205	64581
24346	29807	45136	67225
25001	29824	49491	76085
25024	29900	49492	76362
25025	29901	52001	76394
25259	29902	52347	76490
25275	29999	53431	77301
25394	33980	53444	77418

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The Drug Criteria and Limits list is now available on the Internet at:
www.health.state.ut.us/medicaid/druglimits.pdf
There are links from both the on-line Physician Manual and the Pharmacy Manual.

02 - 49 Diagnosis to Procedure: Code Edits

Bulletin 01 - 96, Diagnosis Must Agree with Procedure Code. . ., published in October 2001, reminded providers that, effective January 1, 2002, claims must have a **diagnosis that fits the procedures completed, or they will be denied.** A diagnosis code in addition to the V code **must also be** on the claim form. Make sure that the diagnosis and procedure codes agree! [The October bulletin is on-line at www.health.state.ut.us/medicaid/october2001.pdf]

Diagnosis and Procedure Incomplete, or Not in Agreement

A number of claims reviewed since January 1, using the clinical claims editor program, continue to have instances where the diagnosis does not fit the procedures listed on the claim, or the claim is submitted with only a V-code for the diagnosis. Claims submitted with only a V code will not be paid, with the exception of child health exams. Claims submitted with a diagnosis which does not agree with the procedure completed will be denied. Here is an example: A claim for CT of the abdomen which is submitted with diagnoses of headache and myalgia will not be paid.

Medicaid must have an accurate record of the diagnosis and procedures on submitted claims to evaluate programs and payment trends, and have accurate records. Claim payment to providers is delayed when inaccurate diagnoses are submitted. Other insurance providers including Medicare are using editing programs that review procedure to diagnosis issues. If you have questions, call Medicaid Operations. Staff can assist with training and/or provide a list of procedure-to-diagnoses for a particular issue of concern.

SECTION 1 Updated

Information on diagnosis and procedure codes was added to SECTION 1 of the Utah Medicaid Provider Manual, as a new Chapter 8 - 4, Diagnosis Must Agree with Procedure Code; Use of 'V' Codes. View the update in the on-line version of SECTION 1, page 30B.
www.health.state.ut.us/medicaid/SECTION1.pdf

Diagnosis to Procedure: Examples of Problems with Claims

During claim reviews, some common problems were noted. A summary of these follows. Please review the examples and ask for instruction as needed. Medicaid Operations staff offer training and can give you a list of procedure-to-diagnoses for a particular issue of concern.

Anesthesia and Surgery

1. With any anesthesia procedure code, please list the diagnosis biopsy procedure or surgical procedure diagnosis code.
2. When doing OR procedures, please list the OR procedure diagnosis code along with the other diagnoses that lead to the need for surgery.
3. Procedure code 62311,epidural lumbar sacral area injections,will be denied when billed with an unspecific diagnosis. As stated in the Utah Medicaid Provider Manual for Physician Services, the epidural lumbar sacral injection is covered for pain management related to labor and delivery and/or post surgical pain during the post operative period. Unspecified diagnoses that have been billed and will deny with the diagnosis-to-procedure edit include: 625.9–female genital symptoms unspecified, 724.2–lumbago, 724.3–sciatica, 724.4–lumbosacral neuritis unspecified, 724.5–backache unspecified, 724.6–disorders of the sacrum, 729.1–myalgia and myositis unspecified, 729.5–pain in limb, 789.0–abdominal pain unspecified, 789.9–abdominal/pelvic symptoms unspecified
4. A diagnosis-to-procedure edit will deny the claim when the service is related to a non-covered procedure code such as sleep disturbance 780.59, cephalic version–652.1, or a code unrelated to the procedure, such as hypertension 401.9 or V123, and obesity 278. A diagnosis-to-procedure edit will occur with a chronic pain or generalized diagnosis code such as upper quadrant abdominal pain (789.3, 789.4) or pelvic pain 627.0, prostate cancer 185, other disorders of the intestine 569, chronic ischemic heart disease 414.9, or cervicalgia 723.1.
5. Billing for 62311 in addition to anesthesia for "normal delivery 650" is not covered.

Follow-Up Care

The original injury or procedure diagnosis should be on the claim when an x-ray or other follow-up examination is submitted. When the claim only contains a V follow-up code or unrelated diagnosis, an diagnosis-to-procedure edit will deny the claim.

Laboratory

1. The physician diagnosis provides a link to the laboratory testing and, without a differential diagnosis to support testing, a diagnosis-to-procedure edit will occur. When billing a cytopathology code like 88104 or surgical pathology code like 88305, the diagnoses must include the surgical procedure or biopsy procedure to indicate what specimen was obtained for the pathology study.
2. When 80164, Valproic acid, and 80178, Lithium, are ordered to test for drug levels, add several

diagnoses codes to indicate the reasons for testing. The differential diagnoses should indicate to the editing program that the test is related to treatment with a psychotropic or antiepileptic drug.

3. The following diagnoses will cause a diagnosis-to-procedure edit if the procedure ordered is a Group A streptococcus screen: Headache, otitis externa NOS, gastroenteritis, and/or chronic diarrhea. Because of the diagnoses found on review with Group A screen, a viral syndrome or unspecified virus alone will not be accepted for coverage. Some indication of the site of infection and/or type of infection must be included on the claim.
4. When code 83036, glycated Hgb or 82043-82044, microalbumin, are billed, a diagnosis related to diabetes which supports these tests must be on the claim.
5. **When the CPT codes 87797, 87510 or 87480 for DNA probes are billed, only one of the three codes will be paid to the physician.** This follows federal Medicare guidelines, as clinical examination should lead to a focus in the differential diagnosis and a focusing of the laboratory tests required for diagnosis of vaginitis, etc.
6. The laboratory studies ordered should be explained by a diagnosis on the claim. It is expected that laboratory studies will be focused on the problems identified and not duplicate one another. When different diagnostic tests are ordered that study the same issue, or the same test is repeated numerous times, the medical record may be reviewed at a later date.

Pregnancy and Delivery

- Claims listing both 01961 (*00850*) and 01967 (*00955*) will deny for diagnosis-to-procedure edit. If the diagnosis involves a Cesarean section (C/S) following neuraxial anesthesia, the correct code prior to Year 2002 was 00857, neuraxial anesthesia followed by C-section. **In the 2002 CPT manual, the code was changed to 01968 and stated as an add-on code. Medicaid allows payment for only one anesthesia service. The add-on code will not be paid in addition to another anesthesia service code. The higher of the two submitted codes will receive payment.**
- Use the pregnancy related procedure if the patient is pregnant. For example, diagnosis 640 hemorrhage in early pregnancy submitted with 76856, Echography non OB pelvis; complete, will deny. The proper code should be 76805, echography pregnant pelvis; complete.

Other

- Procedure codes for skin debridement like11041 and 11042 will post a diagnosis-to-procedure edit when the diagnoses are listed as diabetes or peripheral neuropathy. Diagnoses should indicate the specific problem being diagnosed or treated. In this case, diagnoses codes for diabetic ulcer and/or infected open wound should be included on the claim.
- Code J0696, Injection ceftriaxone submitted with 90790--IV infusion therapy. The editing program will find cases where the drug is only given IM and an IV infusion therapy code is charged.
- Code 76700, abdominal echography, submitted with hematuria as the diagnosis. With an imaging study, a diagnosis-to-procedure edit may occur if the diagnoses are unspecific or only one symptom. Additional differential diagnoses beyond one symptom should be added to help support imaging studies (i.e. pyelonephritis). When codes for CT scan of the pelvis (72191 to 72194) are ordered, and the claim diagnosis is related to abdominal pain, the claim will post a diagnosis-to-procedure error. The imaging studies ordered must be related to a diagnoses on the claim.
- **Billing for 95951, video EEG monitoring, is covered for intractable epilepsy when other diagnostic tests have failed to provide a diagnosis and it is the most reasonable diagnostic test to use.** Other conditions which may cause non-epileptic seizures, such as cardiac arrythmias, transient ischemic attacks, syncope, or narcolepsy, have been ruled out. This test is not covered for non covered issues such as sleep disorder studies.

V codes

The October Bulletin 01 - 96 also reminded providers that a diagnosis code in addition to the V code **must also** be on the claim form. Two examples of the use of V codes were given in that bulletin and can also be found in SECTION 1, Chapter 8 - 4, Diagnosis Must Agree with Procedure Code; Use of 'V' Codes. Policy names certain V codes that can be used for procedures for children, such as V codes related to routine child health examinations.

1. The following V codes are added to policy:
   - V71.81 and V71.5 for observation and care of children requiring assault/or and neglect care.
   - V059 (vaccine for single disease) for children with RSV.
2. For adults, Medicaid will allow codes V10.3, V76.19, and V76.11 for mammography codes 76090, 76091, 76092. Also, code V76.12 will allow 76092 through the diagnosis-to-procedure edit.
3. Code V221, supervision of normal pregnancy, and V288, Antenatal screening, will be allowed only for laboratory provider use with the obstetrical panel 80055, treponema pallidum confirmatory test 86781.

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02 - 50 Centers for Medicare & Medicaid Services, formerly the Health Care Financing Administration

The Health Care Financing Administration is now the Centers for Medicare & Medicaid Services (CMS). In a press release on June 14, 2001, the Secretary of Health and Human Services, Tommy G. Thompson, announced reforms designed to strengthen health care services and information for nearly 70 million Medicare and Medicaid beneficiaries and the health care providers who serve them. The name change for the agency emphasizes these two popular programs.

A new website for CMS has been launched at http://cms.hhs.gov/. The agency is building an easy-to-use website with more content and services than the old web site, www.hcfa.gov. During the transition, there are a large number of links to take you to specific pages on the old website.

Renaming of HCFA 1500

The Centers for Medicare and Medicaid Services is in the process of revising all documents and forms to reflect the agency's new name. The HCFA 1500 is now being referred to as the CMS 1500, but this name change has not yet been completed on all pages of the CMS web site. As current supplies of printed materials are depleted, the Government Printing Office will reprint the HCFA 1500 and replace "HCFA" with "CMS" on the new form.

More Information about CMS

The press release of June 14, 2001, is available at www.hhs.gov/news/press/2001pres/20010614a.html. It covers restructuring of the agency, a national Medicare education campaign, and reforming the Centers for Medicare & Medicaid Services relationship with the private companies that process and pay fee-for-service Medicare claims. Other points include the agency's name change, organization, and culture. ☐

02 - 51 Zyban as a Part of Smoking Cessation Therapy

Zyban is a non-nicotine pill that helps smokers to quit by interacting with chemicals in the brain to reduce nicotine cravings. Medicaid may now cover Zyban, with prior approval, for Medicaid clients age 18 and older. Formerly, coverage was restricted to pregnant women. The criteria for coverage are on page 27 of the Drug Criteria and Limits List dated April 2002. [Note: Funding for this product comes from the Utah tobacco settlement. When funding is discontinued, coverage of Zyban will be discontinued.]

Facts about Zyban

- Brand Name: Zyban
- Generic Name: Bupropion Hydrochloride – Sustained Release Tablets.
- Company: Glaxo-Wellcome.
- Indication(s): an aid to smoking cessation.
- Available by prescription only.
- Approved by the Food and Drug Administration in 1997.

Contraindications

1. Patients treated with Wellbutrin or any other medications that contain bupropion. Zyban is an anti-depressant and should not be taken with other anti-depressants unless under a doctor's supervision.
2. Patients with a current or prior diagnosis of bulimia or anorexia nervosa.
3. Patients taking mono-amine oxidase inhibitors (MAOIs).
4. Patients who have shown a hypersensitivity to bupropion.
5. Patients who have taken MAO inhibitors must wait at least 14 days between the discontinuation of MAO inhibitor therapy and the commencement of Zyban therapy.

Administration

The recommended and maximum dose of Zyban is 300 mg/day given as 150 mg, twice daily. Dosing should begin at 150 mg/day for the first three days followed by an increase to the usual dose of 300 mg/day. Treatment should be initiated while the patient is still smoking, and a target date for smoking cessation should be within the first two weeks of treatment. Zyban therapy should continue for 7 to 12 weeks, depending on the effect of the therapy. If the patient has not reduced smoking by the seventh week of Zyban therapy, it is unlikely that she will quit during that attempt, and Zyban therapy should be discontinued.

Efficacy

Zyban clearly works, as demonstrated in a paper published in the October 23, 1997 issue of the New England Journal of Medicine. The study of more than 600 smokers compared three different doses of the drug and a placebo over seven weeks. At the end of

treatment, 44 percent of those who took the highest dose of the drug (300 mg) were not smoking, compared to 19 percent of the group who took a placebo. By the end of one year, 23 percent of the 300 mg group and 12 percent of the placebo group were still smoke-free.

Medicaid Criteria for Coverage of Zyban

For complete criteria, refer to the Drug Criteria and Limits List, updated to April 2002. This list is an attachment to two Utah Medicaid Provider Manuals: Physician Services and Pharmacy Services. ☐

02 - 52 Smoking Cessation Services for Pregnant Women

Health care providers, you are **extremely** influential in promoting smoking cessation.

- Each year, 1.7 million more smokers would quit if a health care provider advised them to do so.
- Pregnant women say that prenatal visits are an ideal time for smoking cessation advice [1].
- Research confirms that one 5 to 15 minute counseling session during pregnancy by a trained provider with appropriate printed materials nearly doubles the normal cessation rates of 5 to 10% without counseling to almost 20% [2].

Medicaid staff are committed to contacting new Medicaid enrollees who are pregnant and use tobacco to assist them in enrolling in cessation services. Your support in raising awareness of cessation will help more mothers quit using tobacco.

Extent of the Problem of Smoking Among Pregnant Women

- According to The American College of Obstetrics and Gynecology, infant and fetal deaths could be reduced by as much as 10% by eliminating smoking among pregnant women [3].
- It is estimated that 19-30% of women smoke during pregnancy [1].
- Only about 20% of women quit smoking on their own while pregnant, and most resume smoking after giving birth[2].
- Over 20,000 Utah women smoked during pregnancy during the years 1993 through 1998. More than 5,000 of these were teens [2].

How To Help: 5 Quick and Easy Intervention Steps

The Public Health Service recommends that health care providers use the following **5 A's** as a brief intervention during a tobacco user's office visit [3]. Medicaid services for pregnant women assist providers in fulfilling the 5 A's.

1. ASK Systematically identify pregnant tobacco users at every visit. Incorporate smoking status as fifth vital sign.

2. ADVISE In a clear, strong, and personalized manner, urge every tobacco user to quit.

3. ASSESS Determine patient willingness to make a quit attempt.

4. ASSIST If patient is willing to make a quit attempt, help set a quit date and inform about Medicaid services that are available.

Inform pregnant women enrolled in Medicaid about the cessation services available to them: counseling and support programs and nicotine replacement therapies. Medicaid will cover nicotine replacement therapies and Zyban for pregnant women **only** when requested by the physician.

5. ARRANGE Schedule follow-up contact.

When you assist a pregnant woman with cessation services, Medicaid staff will follow-up to verify her participation in a cessation program. This combined effort will support the woman in her efforts to quit smoking.

Support Services for Pregnant Women

The Medicaid tobacco-cessation program is designed to meet the needs of pregnant women in the following ways:

- Offer support to help pregnant women quit smoking.
- Focus on lifestyle, social, and emotional issues facing pregnant women.
- Teach strategies to help pregnant women quit smoking for life.
- Provide pharmacological aids when appropriate.

If your patient is a pregnant Medicaid client, refer her to **Julie Olson** at **801-538-6303**, or send an email message to "jolson@doh.state.ut.us", for information on the free services available in her local area. For pregnant women not eligible for Medicaid, refer them to the Quit Line at 1-888-567-TRUTH. The Quit Line provides smokers with tailored telephone-based tobacco cessation counseling.

Preventing Relapse

Relapse prevention is especially important for pregnant women because 70% begin smoking again within the first year after giving birth [4]. Having a partner or friends who smoke is a predictor for returning to smoking. Encourage patients to have a plan for coping with friends who smoke. If a lapse occurs, remind patients that it takes most people two to eight quit attempts to stop smoking for good. A lapse is often part of the smoking cessation process.

Remember:

The most important step your patient can take to improve her health and the health of her baby is to stop using tobacco.

Article submitted by the Divisions of Health Care Financing and Tobacco Prevention & Control Program. Portions of this article are taken, with permission, from Dr. T. Lewis article from the Utah Medical Association Bulletin, February 2000, Vol. 48, No. 2.

FOOTNOTES

1. American College of Obstetricians and Gynecologists. (1997, September). Smoking and Women's Health. ACOG Educational Bulletin, 240.

2. Utah Department of Health (2000, January). Maternal and child health internet query module on-line at http://hlunix.hl.state.ut.us/matchiim/main/

3. Strobino D & Sliver GB (1998). Effects of smoking on perinatal and women's health. Perinatal and Women's Health Issues Summary 9, 1-4.

4. Hershberger P. (1998). Smoking and pregnant teens. Lifelines: Association of Women's Health, Obstetric, and Neonatal Nurses, 2(4), 26-31.

5. Mullen PD. Maternal smoking during pregnancy and evidence-based intervention to promote cessation. In: Spagler JG, ed. Primary care: clinics in office practice. Philadelphia: WB Saunders, 1999;26:577-589.

6. Fiore MC, Bailey WC, Cohen SJ, et al. Treating Tobacco Use and Dependence. Clinical Practice Guideline. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service. June 2000.

7. Mullen PD, Carbonari JP, Tabak ER & Glenday MC. (1991) Improving Disclosure of Smoking by Pregnant Women. American Journal of Obstetrics and Gynecology. 165: 409-13.

8. Floyd RL, Zahniser SC, Gunter EP, & Kendrick JS (1991). Smoking during pregnancy: Prevalence, effects, and intervention strategies. Birth, 18(1), 48-53.

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02 - 53 Utah Tobacco Quit Line

The Utah Medicaid Program, in a cooperative arrangement with the Tobacco Prevention and Control Program, covers services provided to Medicaid clients by the Utah Tobacco Quit Line. [Note: Funding for services comes from the Utah tobacco settlement. When funding is discontinued, services may be discontinued.]

Tobacco Quit Line: **1-888-567-TRUTH**
1-888-567-8788

Hours of operation are:
Monday – Thursday, 11:00 a.m. – 10:00 p.m.
Friday, 10:00 a.m. – 6:00 p.m.
Saturday, 10:00 a.m. – 2:00 p.m.

The Quit Line offers slightly different services depending on the age of the caller. The Teen Tobacco Quit Line* targets teenagers. The Utah Tobacco Quit Line serves adults, those age 20 and older. Please refer pregnant women who need smoking cessation services to the Medicaid tobacco-cessation program, rather than to the Quit Line. This program is designed to meet the needs of pregnant women. Refer to bulletin 02 - 52, Medicaid Smoking Cessation Services for Pregnant Women.

* For more information about the Teen Quit Line, refer to the January 2001 issue of the Medicaid Information Bulletin, 01 - 04 Utah Teen Tobacco Quit Line: Telephone-based Resource for Teenagers. [on-line at www.health.state.ut.us/medicaid/january2002.pdf

Persons who call the Quit Line are eligible for one or more of the levels of service described below.

Level 1: Information and referral

For callers not interested in quitting, or those looking for referral information only, resources and materials will be provided. A comprehensive database will allow callers to be referred directly to local cessation programs.

Level 2: Brief intervention and counseling

Callers who are not yet ready to quit will speak with a trained Cessation Specialist for up to 15 minutes. The specialist will help the caller explore reasons for quitting and steps to take toward a successful quit attempt.

Level 3: Single in-depth intake and counseling

Callers who are ready to quit will speak with a trained Cessation Specialist for up to 45 minutes. The specialist

will explore the caller's pattern of tobacco use, barriers to successfully quitting, and strengths that would contribute to a successful quit attempt.

Callers interested in additional follow-up beyond the single call intervention can enroll in the Quit Line's intensive telephone-based program or in a locally based cessation program of the caller's choice.

Callers not interested in additional follow-up will be encouraged to call the Quit Line again and will receive information by mail.

Callers interested in locally based resources will be referred to resources in their area.

Level 4: Intensive cessation program

Callers interested in receiving follow-up services can enroll in the Quit Line's intensive telephone-based program that includes a series of four calls. A Cessation Specialist will provide a focused, purposeful intervention designed to enhance motivation and to facilitate behavior change. Nicotine replacement products may also be provided to Medicaid clients and uninsured persons.

Free Quit Kit

Callers may receive a free Quit Kit at any level of service. The kit includes the latest tobacco cessation information, written to meet the needs of readers at all literacy levels. The kit also includes a packet filled with items that can be used in lieu of tobacco, e.g., a worry stone, straw, etc. [The Quit Kit was developed by Group Health Cooperative's Center for Health Promotion, in partnership with the Oregon Health Department.]

Center for Health Promotion

The Utah Department of Health contracted with the Center for Health Promotion at Group Health Cooperative to operate the Utah Adult Quit Line. The Center holds primary responsibility for the development, implementation, and evaluation of health promotion and preventive care programs for work sites, members, and the community at large. It currently operates statewide Quit Lines in Georgia, Maine, Minnesota, Oregon, Washington, and Wisconsin, as well as the Teen Quit Line in Utah. The center has been actively engaged in tobacco cessation and prevention work for over 15 years. Group Health received the American Association of Health Plans' first place award for Managed Care Achievements in Tobacco Control, Public/Private Partnerships in 1999 and 2000.

How the Quit Line was developed

The Quit Line was modeled after Group Health Cooperative's *Free & Clear*® telephone-based tobacco cessation program. In a randomized research trial funded by the National Cancer Institute (1991), *Free & Clear*®, combined with self-help materials, was shown to boost quit rates by over 50% compared to controls. The effectiveness of telephone-based interventions was endorsed by the Public Health Service in its tobacco cessation Clinical Practice Guideline *Treating Tobacco Use and Dependence* (June 2000).

How the Quit Line will be evaluated

A formal evaluation of the Quit Line will be performed annually. A telephone survey of several hundred callers will be conducted six months after their initial Quit Line inquiry. The survey will include questions to determine caller satisfaction with Quit Line services and their current tobacco use status. ☐

TRAINING OPPORTUNITY

Smoke-Free Families Training

- Implementing the U.S. Public Health Service "Five A's" to promote smoking cessation among pregnant and parenting women and their families.
- April 15, 5:30 to 9:30 p.m. at the University Park Marriott Hotel, Salt Lake City, Utah.
- $20.00 registration fee to help offset the costs of the 2.5 hours of Continuing Medical Education units that will be offered.
- Sponsored by the Utah Department of Health's Reproductive Health Program, the Association of Maternal & Child Health Programs and Health Insight.
- For further information contact Lois Bloebaum at (801) 538-6792.